

IFAITH & W

C. L. "BUTCH" OTTER - Governor RICHARD M. ARMSTRONG - Director DEBRA RANSOM, R.N., R.H.J.T., Chief **BUREAU OF FACILITY STANDARDS** 3232 Elder Street P.O. Box 83720 Boise, ID 83720-0036 PHONE 208-334-6626 FAX 208-364-1888

November 25, 2008

Rex Redden Idaho Falls Group Home #3 Periska P.O. Box 50457 Idaho Falls, Idaho 83405-0457

Provider #13G045

Dear Mr. Redden:

On November 10, 2008, a complaint survey was conducted at Idaho Falls Group Home #3 Periska. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00003833

Allegation #1: Individuals are not being changed when they are wet on the night shift.

Findings: An unannounced on-site investigation was conducted on 11/3/08 - 11/10/08. During that time, facility staff were interviewed and records were reviewed with the following results:

> During an observation on 11/4/08 from 4:55 - 5:15 a.m., two night shift staff that were present were interviewed regarding procedures for incontinence care. Both staff stated that all individuals were checked every 2 hours and changed as necessary. Toileting records for the facility were reviewed and documented checks were occurring at least every two hours.

> Additionally, five day shift staff were interviewed on 11/5/08. All five staff stated they had not found individuals wet when coming on duty.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

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Allegation #2: An individual's C-Pap mask is old and fits too tightly.

Findings: An unannounced on-site investigation was conducted on 11/3/08 - 11/10/08. During that time record review, observation, and staff interviews were conducted with the following results:

The facility's incident and accident reports were reviwed for a six month period. There was no documentation of injuries due to improperly fitted C-Pap masks.

An individual who used a C-Pap machine was observed on 11/4/08 at 9:10 a.m. at the day treatment program and on 11/5/08 at 7:45 a.m. at the facility. The individual showed no signs of injury due to an improperly fitted C-Pap mask.

During an observation on 11/4/08 from 4:55 - 5:15 a.m., two night shift staff were interviewed. Both staff stated an individual in the facility had a C-Pap machine and the mask was checked during the night to ensure proper fit. Both staff stated the individual was able to remove the mask independently.

During an observation on 11/5/08 from 7:45 - 8:10 a.m., an individual's C-Pap mask was observed to be in good condition.

The home supervisor was interviewed on 11/5/08 at 4:00 p.m. and stated the mask was replaced as needed and checked by nursing staff to ensure proper fit.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: Criminal background checks are not being completed on new staff.

Findings: An unannounced on-site investigation was conducted on 11/3/08 - 11/10/08. During that time, facility staff were interviewed and records were reviewed with the following results:

Five direct care staff were interviewed on 11/5/08. All staff reported background checks had been required and that newly hired staff were not allowed to work alone with clients until their background checks were completed.

Supervisory staff were interviewed on 11/5/08 at 8:00 a.m. and at 4:00 p.m. Supervisory staff also stated background checks were completed on the day staff were hired if the staff would be working clients prior to orientation class.

The facility's criminal history check records were reviewed on 11/5/08 and documented criminal background checks were being completed.

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Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #4: The night shift is under staffed.

Findings: An unannounced on-site investigation was conducted on 11/3/08 - 11/10/08. During that time, facility staff were interviewed and records were reviewed with the following results:

Two night shift staff were interviewed on 11/4/08 from 4:45 - 5:15 a.m. Both staff stated they had never been required to work alone. Both staff stated they were not aware of any night shift staff having to work alone.

Five day shift staff were interviewed on 11/5/08 from 7:45 - 8:10 a.m. All staff stated they were not aware of night shift working with any less than 2 staff. All staff stated there were always 2 staff on duty when they arrived at work.

Additionally, the facility's as-worked schedules were reviewed for the period of 6/08 - 11/5/08. There was no documentation that the night shift was working under staffed.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #5: There is no first aid kit in the facility.

Findings: An unannounced on-site investigation was conducted on 11/3/08 - 11/10/08. During that time observation and staff interviews were conducted with the following results:

During an observation on 11/4/08 from 4:55 - 5:15 a.m., two night shift staff were asked if the facility had a first aid kit available. The staff were able to show surveyors the location of two first aid kids within the facility.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #6: Staff are not provided essential training.

Findings: An unannounced on-site investigation was conducted on 11/3/08 - 11/10/08. During that time, facility staff were interviewed and records were reviewed with the following results:

Two night shift staff were interviewed on 11/4/08 from 4:55 - 5:15 a.m. Both staff stated they had received training from senior and supervisory staff prior to working with individuals residing in the facility.

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Both staff stated they had received training with regards to emergency evacuations, first aid, CPR and basic familiarization with the individuals and the facility (e.g. locking up chemicals, where the first aid kit is, etc.).

Five direct care staff were interviewed on 11/5/08 from 7:45 - 8:10 a.m. All five staff stated they had received training with regards to emergency evacuations, first aid, CPR and basic familiarization with the individuals and the facility (e.g. locking up chemicals, where the first aid kit is, etc.). Additionally, the Lead Worker, who was present, stated he was the primary person responsible for training new staff regarding the basics of the facility. The Lead Worker stated training records were maintained in individuals personnel files.

On 11/5/08 from 4:00 - 4:25 p.m., no less than 10 current staff training records were reviewed and documented all staff had been through a systematic training process.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As none of the complaints were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

JIM TROUTFETTER
Health Facility Surveyor

Non-Long Term Care

NICOLE WISENOR

Co-Supervisor

Non-Long Term Care

JT/mlw